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AUTHOR Hinrichsen, Gregory A.
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ABSTRACT

For the vast majority of persons of all ages who suffer from major depression, it is recurrent. A traditional wisdom has been that elderly persons respond more poorly to treatment for serious depression than younger persons. The psychiatric status of 127 elderly persons hospitalized for an episode of major depression was systematically assessed for one year. The rates of recovery and relapse were virtually identical to studies of younger patients. However, almost three quarters of this group of older people had recurrent depression, and a year after hospitalization, only one-third were symptom free. More vigorous antidepressant medication treatment of late life depressive illness to prevent recurrence was advocated at the National Institute of Health Consensus Conference on Late Life Depression. Some geropsychologists were outraged at the almost exclusive emphasis on somatic intervention. Unfortunately, well designed psychological intervention studies for depression are few in number. It is suggested that psychotherapeutic treatments for depression with demonstrated efficacy in younger people can be productively applied to older adults. The Geriatric Psychiatry Division at Long Island Jewish Medical Center is described as it presents one model of a continuum of care, with psychologists playing an important role in the system. Contains 23 references. (JBJ)

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Late Life Recurrent Depression: Challenge to Mental Health Care

Gregory A. Hinrichsen, Ph.D.
Geriatric Psychiatry Division and Psychological Services
Hillside Hospital Division, Long Island Jewish Medical Center
Glen Oaks, N.Y.

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To argue that depression in late life may be recurrent or that a well-integrated service system is needed for depressed elderly seems pretty obvious to anyone in the mental health field. A comprehensive continuum of care for people with psychiatric problems was the vision of community mental health center advocates in the 1960's. So why discuss it again? Well, the vision wasn't realized or only partly so. As clinicians we may want to continue to see psychiatric problems as acute. There is something satisfying about helping an older person resolve the mental health ramifications of a circumscribed late life stressor. It may be less gratifying to help an older adult manage the emotional, practical, interpersonal, and even existential fall-out from the fifth late life episode of major depression for which there is no apparent precipitant. For me, as director of an internship training program, the gap between the clinician's understandable desire that problems be circumscribed and quickly resolvable vs. clinical reality is brought into focus each year when psychology interns express surprise and disappointment about the recurrent nature of mental illness. I imagine interns whispering to each other, "They seem

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to get better, but why don't they stay better?"

Most substantively, I think it is important to review research data from the last fifteen years that has underscored that, for the vast majority of persons of all ages who suffer from major depression, it is recurrent. The best source of data on the recurrent or chronic nature of serious depression comes from the National Institute of Mental Health Collaborative Study of the Psychobiology of Depression begun in 1974 and which has studied almost 1,000 depressed persons (Katz, et al., 1979).

Findings reported from the Study in the early 1980's were sobering. In a mixed-age group of persons treated for major depression with antidepressant medication over the period of one year, almost three-quarters recovered from the episode. However, one-third of those who recovered subsequently relapsed within the year (Keller & Shapiro, 1981). In a two year follow-up, fully 21% of patients had yet to recover from the index episode of depression (Keller, Klerman, Lavori, Coryell, Endicott, & Taylor, 1984). At five years, 12% of this group of patients remained continuously in a major depression (Keller, Lavori, Mueller, et al., 1992).

What is the course of major depression in the elderly? To further darken the therapeutic sky, a traditional wisdom has been that elderly persons respond more poorly to treatment for serious depression than younger persons. As part of the NIH Consensus Development Conference on the Diagnosis and Treatment of Depression in Late Life, Elaine Murphy reviewed existing data on the course and outcome of depression in the elderly. She noted that most studies are flawed by a variety of methodological

problems. She concluded, however, "...all studies have shown that elderly depressed patients have a high risk of not recovering, and if they do recover, subsequent relapse becomes increasingly likely with the passage of time." (Murphy, 1994 p. 94) But do elderly person with depression indeed do more poorly than younger persons? Studies that compare rates of recovery and relapse between younger and older depressed patients are rare.

Data from our own research address this question. Within a larger study of family issues in late life depression we systematically assessed for one year the psychiatric status of 127 elderly persons from the time they were hospitalized for an episode of major depression. Worth noting is that 73% of patients had had prior episodes of major depression. For almost three-quarters of the patients, the first episode of major depression had occurred after age 50.

Since we used the same methodology to assess and prospectively follow the course of depression as that employed in the NIMH Collaborative Study of Depression, we could directly compare rates of recovery and relapse over one year between our sample of elderly patients with those found in the Collaborative Study's sample of primarily younger patients. As can be seen from the Table (Slide 1), the rates were virtually identical indicating that elderly persons do not do better or worse than younger persons (Hinrichsen, 1992). That's the "good" news. The bad news is apparent from the pie chart (slide 2). Although the majority of elderly patients recovered and did not relapse only 34% recovered and subsequently did not show any symptoms of

depression during the one year follow-up. Other recovered, non-relapsing patients continued to evidence or subsequently evidenced minor affective symptoms or minor depressive disorder. This is despite the fact that all patients were receiving ongoing psychiatric care. To summarize, almost three quarters of this group of older people had recurrent depressions and a year after hospitalization, only one-third were symptom free. The need for an ongoing and integrated system of mental health care for older people with major depression is fairly compelling.

Although most patients respond well to the acute treatment of depression, why do both younger and older patients fare so poorly in the longer-term even when receiving mental health services? (Or to soften it, "fare less well than than we would expect".) The psychiatric perspective is that patients have not been treated aggressively enough with antidepressant medication. Indeed, Keller and colleagues (1982) reported in findings from the Collaborative Study that most patients were receiving inadequate doses of antidepressant medication. More vigorous antidepressant medication treatment of late life depressive illness to prevent recurrence was advocated at the NIH Consensus Conference on Late Life Depression (Frank, 1994). A recent editorial in a major geriatric psychiatry journal also suggested that poor treatment outcomes in the elderly reflected lack of psychopharmacological vigor (Bonner & Howard, 1995). However, it failed to mention any possible role of psychosocial interventions in improving treatment outcomes (Hinrichsen, in press). Is more psychiatric medication the answer? It is one answer but one that I believe is incomplete.

Some geropsychologists were outraged at the almost exclusive emphasis on somatic intervention in the treatment of late life depression by the NIH Consensus Conference on Late Life Depression (NIH Consensus Development Statement, 1991). Unfortunately, relative to available evidence on the somatic treatment of late life depression, well-designed psychological intervention studies for depression are few in number. The well-designed studies that have been done -- most notably work by Gallagher-Thompson, Thompson, and Teri -- support the efficacy of short-term cognitive-behavioral and psychodynamic therapies in the treatment of depression -- with indications that they have longer-term (i.e., one year) efficacy. There are many other studies of psychosocial interventions for the treatment of late life depression (Scogin and McElreath, 1994) but many wish there were more studies of the caliber of those of Gallagher, Thompson, and Teri. Nonetheless, there are many more similarities than differences in the presentation, course, and treatment outcome of depression between younger and older people. I believe that a convincing argument can be made -- even to managed care companies -- that psychotherapeutic treatments for depression with demonstrated efficacy in younger people can be productively applied to older adults. The report of APA's Division of Clinical Psychology's Task Force on Promotion and Dissemination of Psychological Procedures (1995) recently provided a useful summary of psychological treatments (including those for depression) for which there is solid empirical support. Alas, there are very few good studies that have examined the long-term

utility of either specific psychopharmacological or psychotherapeutic interventions for depression.

The view that higher doses of medication and increased patient compliance with those medications is the answer to recurrent depression ignores the fact that the effect of serious depression reverberates throughout the patient's world. Depression takes place within an interpersonal context. A large and convincing body of research demonstrates that serious depression damages interpersonal relationships. Again drawing upon data from the NIMH Collaborative Study of Depression, researchers found that after five years the psychosocial consequences of affective disorder were "surprisingly severe, enduring, and pervasive." (Coryell, et al., 1993; p. 723). Further, interpersonal relationships have a potent influence on the course of depression and that this influence may be especially important in late life depression (Keitner, Miller, & Ryan, 1994). In younger patients, relapse rates are much higher among patients with relatives who evidence hostility, criticism, and emotional overinvolvement toward them (so called "high expressed emotion" (EE) families) (Hooley, Orley, & Teasdale, 1986). Several interventions have demonstrated efficacy in changing family behaviors reflecting the EE construct with concurrent reductions in subsequent patient relapse (Anderson, Hogarty, Reiss, 1980). Related work has also demonstrated the efficacy of marital therapy as the treatment for depression when there is a concurrent marital problem (Beach, Sandeen, & O'Leary, 1990).

In our own study of depressed elderly inpatients and their

family members, that was noted earlier, we found that only family-related issues (and not clinical or demographic factors) were tied to recovery and relapse over one year (Hinrichsen & Hernandez, 1993); that family relationship strains were one of the few predictors of suicidal behavior over one year (Zweig & Hinrichsen, 1993); and that family member EE was tied to risk of relapse in ways unique to later life (Hinrichsen, under review). In view of these findings, it is worth mentioning that there is an ongoing study of the short and long-term of efficacy of Interpersonal Psychotherapy for depressed elderly the results of which will be of considerable interest to geropsychologists (Frank, et al., 1993).

The bottom line is that there is a solid rationale for delivering psychological services to older adults with recurrent depression based on data from younger age groups and more circumscribed data on older adults. Such interventions hold promise for reducing the length and frequency of those episodes. The use of well-defined individual, family and marital interventions that have been at least empirically validated with younger age groups is important.

While depressive illness exists within an interpersonal context it also exists within health care delivery "systems" (or "non-systems" as some have characterized the usual state of affairs.) There have been many studies of the lack of service coordination in both the health and mental health care fields (Swan & McCall, 1987). Suffice it to say, for older adults with recurrent depressive illness, being part of a system that can

monitor and actively respond to the emergence of depressive symptoms and that can call upon an array of psychiatric, psychological, and social work services is what any of us would wish for ourselves or for our elderly relatives.

I am fortunate to work within a system -- the Geriatric Psychiatry Division at Long Island Jewish Medical Center -- that offers such a range of options for the treatment of late life psychiatric disorders. I'd like to describe our system briefly since it presents -- within the resources and of constraints that are specific to our setting -- one model of a continuum of care. Notably, psychologists play important roles in the system.

Our Medical Center primarily serves the racially, ethnically, and economically diverse population of New York City's borough of Queens and suburban Nassau County. The Division has several components including: 1. an outpatient clinic with a census of approximately 500 elderly patients within which is a home visiting program for elderly people unable to leave their homes, (2) an inpatient service of approximately 30 patients, (3) a day/partial hospital with an enrollment of 40 patients, (4) a psychiatric liaison-consultation with our adult medical facility, and (5) a liaison with several community nursing homes. The Division also has a formal academic liaison with a state psychiatric hospital for chronically mentally ill elderly. There are four geropsychologists who work within the Division including myself. Like our psychiatry colleagues, psychology does considerable training in the Division with placements for 5 psychology interns, 7 externs, and 1 post-doctoral Fellow. Staff and trainees provide individual, group,

family, and marital psychotherapies, psychoeducational family interventions, as well as psychological and neuropsychological testing. Psychology staff also teach geriatric psychiatry Fellows and do teaching and consultation at our affiliated state psychiatric hospital.

The benefits of such a system for elderly patients with recurrent depression are potentially great. The level of service can match the level of need. Ongoing contact -- sometimes only intermittent psychiatric visits to monitor medication or monthly psychotherapeutic meetings -- helps to identify the emergence of symptoms or psychosocial difficulties that may potentially trigger symptoms. A five day-a-week partial hospitalization program provides a cost-effective alternative to hospitalization. The availability of a day hospital makes discharge of inpatients easier. There are, of courses, snafus in the movement of patients from one level of service to another -- but they are less likely to happen than in other settings since staff know each other and deliver service under the same administrative umbrella. I would like to underscore one other issue that emerges from my work within this setting: psychologists can and should play an integral role in the delivery of mental health services to the elderly.

The last thirty years have brought numerous advances in the diagnosis as well as psychopharmacological and psychotherapeutic treatment of depression. Research over these years has demonstrated that major depression is a recurrent phenomenon for both young and old. Providing a coordinated system of care for

older people with recurrent depression makes good clinical and well as economic sense and is consistent with the early vision of community mental health advocates.

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